VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
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March 24, 2015

Ms. Morgan Bovat, Administrator
Brownway Residence
328 School Street
Enosburg Falls, VT 05450-5500

Dear Ms. Bovat:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 4, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0118	A. BUILDING: _____ B. WING _____	C 02/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNWAY RESIDENCE	328 SCHOOL STREET ENOSBURG FALLS, VT 05450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted, on 2/3/15 and 2/4/15, by the Division of Licensing and Protection. The following regulatory violation was identified.	R100		
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the home failed to assure that care and services were provided in accordance with the established assessments and identified needs of 3 of 5 residents reviewed. (Residents #1, #2 and #3). Findings include: 1. Per record review a progress note, dated 1/30/15, stated that Resident #2, who had been admitted to the home in July of 2014, had a history of noncompliance with regards to accepting assistance with ADL's (Activities of Daily Living), that s/he was frequently incontinent and would become verbally or physically combative when staff attempted to provide assistance with bathing, personal hygiene, changing wet or soiled clothing or bedding, or cleaning his/her room. The resident's care plan, most recently updated 1/30/15, indicated s/he	R126	See Attached	

R126 - POC accepted 3/23/15 BHW RN/PMC

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R126	Continued From page 1 required 1 assist with grooming, personal hygiene and toileting and stated that s/he was to be toileted every 2 hours. The care plan further noted that the resident required assistance with general cleaning to include daily bed making and housekeeping and directed staff in the following: 'If resident is soiled.....and refusing to wash up or if [his/her] bed is soiled and [s/he] refuses to allow staff to change the bedding, nursing should be notified. Nursing will notify the family. Resident's room will be cleaned while resident is not present in the room as this causes agitation for the resident. Staff should approach resident as directed for ADL's. If resident refuses, staff are to document the refusal and reapproach in 30 minutes. If resident refuses a second time, another staff member will approach the resident to provide assistance. If resident refuses a third time, staff will call his/her [family member]...to notify...of the need for family assistance.' Per observation, on the evening of 2/3/15, between 5:05 PM and 6:30 PM, Resident #2 was seated in the main dining room eating the evening meal. The resident's bedding, noted by the surveyor to be wet during this period of time, was not changed by staff until after the resident had returned to his/her room, and a request was made by the surveyor to change the bedding. During interview, at 7:30 PM on the evening of 2/3/15, PCA (Personal Care Attendant) #1 and #2, both of whom were responsible for assisting Resident #2 with care needs during that shift, confirmed that they had not changed the resident's wet bedding while the resident was out of the room and only did so after the resident had returned to his/her room and the request had made by the surveyor. PCA #1 stated that a resident representative had been to see the resident and s/he assumed that representative might have changed the bedding, however s/he	R126		

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NAME OF PROVIDER DR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNWAY RESIDENCE	328 SCHOOL STREET ENOSBURG FALLS, VT 05450

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R126	Continued From page 2	R126		

did not confirm if it had been done. PCA #3, who was also providing care to residents on the same wing during the shift, confirmed s/he had not changed the bedding.
Per ongoing observation throughout the day of 2/4/15, Resident #2 was not approached by any staff member, between the hours of 8:30 AM and 2:00 PM, to offer assistance with toileting, personal hygiene or any other care needs.
Despite the fact that the resident was observed, at 9:00 AM, attempting to change his/her own incontinence brief, no assistance was provided by staff. Although the resident was observed in the dining room between 11:45 AM and 12:30 PM, the bed, which had covers pulled up over a wet bottom sheet, as observed by the surveyor at that time, was not changed by staff and the resident was observed sleeping under the covers in the bed at 2:30 PM.
PCA #3 confirmed, during interview at 2:00 PM on 2/4/15, that s/he had been responsible to assist Resident #2 with care needs during that shift and, as of 2:00 PM had not approached the resident to assist with toileting or personal hygiene needs and had not attempted to change the resident's bed or assist in cleaning his/her room. During another interview, at 2:30 PM, PCA #3 stated s/he had approached Resident #2, between 2:00 and 2:30 PM, to offer assistance with care and, although the resident had refused, s/he had not reapproached and/or notified nursing of the resident's refusal for care, in accordance with the care plan. During interview, at 2:40 PM, Med Tech #1, the only other staff member providing care on the wing on which Resident #2 resided, confirmed that s/he had only administered medication to Resident #2 and had not provided any assistance with personal care needs or bed changes.

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R126	Continued From page 3 2. Per review of Resident #3's record the current Resident Assessment, dated 5/19/14, stated s/he was frequently incontinent of bladder and required extensive assistance with transfer, toilet use, personal hygiene and bathing. A progress note, dated 9/13/14, identified a 'sm area of concern to perineum near L buttock...Area with red/irritation noted from urine, Continues on 2 hours toileting schedule. Pt non-compliant with getting off bottom at times.' A subsequent progress note, on 10/22/2014, stated, '...noted to buttocks area, urinary incontinence irritation. Sm open area of irritation...,encourage pt to walk short distances to provide pressure relief to potential pressure areas.' The resident's current care plan reflected the concern for actual and potential for alteration in Skin Integrity, identified a goal that skin would be intact as evidenced by progression of healing on any open areas and directed staff to 'assist resident to bed twice daily (once in the AM and once in the PM) for approximately 1-2 hours to offload the area off pressure on [his/her] back. Staff will assist resident in getting comfortable on either [his/her] left or right side.' Per ongoing observation, on the morning of 2/4/15, Resident #3 remained in an upright seated position in a recliner chair for a period of 2 hours and 50 minutes without a change of position or assistance to toilet. During interview, at 2:30 PM on 2/4/15, PCA#3 confirmed that s/he had been responsible for assisting Resident #3 with his/her care needs during the 7 AM - 3 PM shift and further confirmed that s/he did not assist the resident to bed or change his/her position while in the recliner between the hours of 8:30 AM and 11:15 AM. 3. Per record review Resident #1's care plan	R126		

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R126	Continued From page 4 stated that the resident required 1 person to assist with grooming and personal hygiene needs, to include daily shaving. Per observation throughout the day on 2/4/15, although the resident had a fairly significant amount of facial hair growth, no assistance had been provided for shaving. During interview, at 2:20 PM on 2/4/15, a resident representative stated they had asked PCA #3 to shave the resident but it hadn't been done. During interview, at 2:30 PM on 2/4/15, PCA #3 confirmed s/he had been responsible, on the 7 AM - 3 PM shift, for assisting Resident #1 with personal care needs and confirmed s/he had not assisted him/her with a shave, stating that Resident #1 only received a shave twice a week.	R126		

R126

5.5.a Upon a residents admission to a residential care home, necessary services shall be provided or arranged to meet the residents personal, psychosocial, nursing and medical care needs.

Action to correct the deficiency

1) The plan of care for resident #1,which requires assistance with grooming and personal hygiene, were updated by Health Services Director (HSD).

   Expected completion date: Completed (3/9/15)

2) The plan of care for resident #2, which required interventions based on non-compliance with care, were updated by the HSD. A formal care plan meeting held in February with the residents POA - approval obtained from POA that care plan meets the needs of resident #2.

   Expected completion date: Completed (2/2015)

3) Plan of care for resident #3,which required interventions based on skin integrity were updated by the HSD.

   Expected completion date: Completed (3/9/2015)

Measures to assure that it does not recur

1) Staff have received additional supervision around following the plan of care and updating nursing if the residents personal care needs have changed and no longer match the plan of care. HSD to communicate with staff via nursing communication note to ensure residents care needs are being adequately met.

   Expected completion date: Completed (3/2015)

2) Staff have received coaching and supervision on the importance of communicating effectively, with nursing, if resident #2 is non-compliant with personal care. HSD to communicate with staff via nursing communication note to ensure residents care needs are being adequately met.

   Expected completion date: Completed (2/2015)

3) Plan of care template has been updated by Brownway Residence to include a "Skin" focus with additional interventions for maintaining skin integrity. HSD to communicate with staff via nursing communication note to ensure residents care needs are being adequately met.

S Martel RN

Expected completion date: Completed (3/2015)

How corrective actions will be monitored

- Going forward the HSD will continue to review flow sheets to ensure appropriate care is being provided as directed by the plan of care.
- Audits will conducted by the HSD, randomly, to ensure staff are following the plan of care and tending to resident's personal care, psychosocial, nursing and medical needs.

Expected completion date: Ongoing

S Markers